

DISCLAIMER: The following sample application is provided for information and reference only. Your application should reflect your individual or group information (depending on provider type) to ensure accuracy.

Map-811 Individual Checklist

NOTICE: Pursuant to 907 KAR 1:672 Section 2 1(c) (1), you must be enrolled as a participating provider prior to being eligible to receive reimbursement. Enrollment in the program is not a guarantee; therefore, providing services to Kentucky Medicaid members prior to your effective date is at your own financial risk.

Did you:

- ◆ Complete all questions? Questions not applicable should be completed with "N/A".
(Applications will be rejected for any questions left blank.)
- ◆ Sign and date signature page (page 10)? *Only original blue ink signatures are accepted. Copied or stamped signatures are not accepted.*
- ◆ Attach appropriate licenses and/or certifications and all other required documents for requested effective date as well as current?
- ◆ Attach verification documentation for NPI and Taxonomy Code(s) from Fox Systems or NPPES.
- ◆ Attach a Map-347 if individual wants to be linked to group KY Medicaid provider number?
- ◆ Attach a copy of your Social Security card if you do not own a FEIN? Attach your IRS verification letter if you are applying as an individual and you are the sole owner of a FEIN?
- ◆ Keep a copy of the application for your records?

Not completing these reminders will delay the processing of your application. Please ensure that all reminders above are completed. Other corrections not mentioned above may be requested during the processing of your application.

Please mail the completed application to the following address:

Kentucky Medicaid
P.O. Box 2110
Frankfort, KY 40602

Please do not send the application to the Department for Medicaid Services. This will delay the processing of your application.

If you have any questions regarding your enrollment, please call Kentucky Medicaid toll free at (877)-838-5085. A provider enrollment specialist will be available to help you between the hours of 8 am and 4:30 pm, EST, Monday through Friday.

MAP-811 Individual Provider Application Instructions

NOTE: Fill out all applicable sections. Indicate Not Applicable (N/A) for questions that do not apply. Applications will be rejected if any questions are left blank.

Please do not re-format or alter application in any manner.

Enrollment Block:

- If applying for a Kentucky Medicaid number for the first time, check first block.
- If re-enrolling as a Kentucky Medicaid number, check second block and enter your eight (8) digit provider number in number 1.
- If a change in Federal Tax Identification number (FEIN) or change in ownership has occurred, check third block.
- If applicant has been excluded from Medicare/Medicaid by Federal, State, or court sanction please declare "I am enrolling as a reinstatement", check fourth block.
- If application is for re-credentialing, please indicate in appropriate box.

Section A: Administrative Information

Field #	Description
1	If a Kentucky Medicaid provider number has already been assigned to this individual, please enter provider number.
2	Enter applicant's name.
3	Enter the date of your license or the date you wish your enrollment with Kentucky Medicaid to be effective.
4	Enter your National Provider Identifier (NPI). Please remember to include your FOX verification.
5	Enter your Taxonomy Code(s) associated with your NPI. Attach extra sheet if necessary. Please remember to include your FOX verification.
6	State the individual Social Security number and date of birth of applicant provider.
7	State Federal Tax Identification Number if provider is sole owner of Federal Tax Identification Number. NOTE: If you are an individual who has incorporated please enter both Federal Tax Identification Number and Social Security Number.
8	Enter the name of the person to sign for a summons in case of a lawsuit. N/A is not acceptable.
9	Telephone number of person named in number 7.
10	List any Kentucky Medicaid Group / Facility numbers you have held in the past three years.
11	If CLIA is attached, please mark block.
12	If Specialty Certification is attached, please mark block.
13	Please enter the county of your physical location.
14	Please enter the supervising physician's name and KY Medicaid provider number.
15	Enter the software vendor (if doing own billing) and/or name of billing agency if someone else is submitting the claims electronically. Please complete Media. Enter magnetic tape; 3.5-inch diskette; 5.25-inch diskette; Asynchronous PC Modem; Synchronous 3780 mainframe or Point of Service.
16	This field is for statistical purposes only and is not required to be completed.

Section B: Disclosure of Ownership and Control Interest

Field #	Description
1	List current Kentucky Medicaid provider numbers.
2	If there has been a change of Federal Tax Identification number, please list previous Medicaid provider numbers and effective dates for each.
3	Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C".

- 4 Do you plan to have a change in ownership, management company or control within the next year? If so, when?
- 5 Do you anticipate filing bankruptcy? If so, when?
- 6 State Federal Tax Identification Number if there is an affiliation with a chain along with name, address, city, state and zip code.
- 7 List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. If owned by a corporation attach sheet with officers and board members names and social security numbers. If you are applying as an individual and do not own a FEIN, please enter your name and information.

NOTE: Do not send the list of board directors unless they own 5% or more.

Indirect Ownership Interest-means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Ownership interest- means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest- means a person or corporation that:

- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or,
- Is a partner in a disclosing entity that is organized as a partnership

- 8 List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

Subcontractor- means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.

- 9 If applicant is related to persons listed in number 8, please list relationship.
- 10 List name of managing company, if not applicable enter N/A.
- 11 List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.

Other Disclosing Entity- means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).
- Any Medicare intermediary or carrier.

- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.

- 12 If entity engages with subcontractors such as physical therapist, pharmacies, etc. which exceeds the lesser of \$25,000 or 5% of applicant's operating expense, please list subcontractor's name and address.

Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5% of applicant's operating expense.

- 13 List name, Social Security Number, address of any provider who is authorized to prescribe drugs, medicine, devices, or equipment.
- 14 List anyone in number 7 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state. Please also indicate any KY Medicaid provider number(s) associated with individual or organization.
- 15 List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the Social Security Act or any criminal offense in this state or any other state. Please also indicate any KY Medicaid provider number(s) associated with individual or organization.

Agent- means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing Employee- means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

- 16 For any current or previous Medicaid provider, please list any changes in administrator; director of nursing; medical director.
- 17 Please indicate where you would like monies paid to you from Medicaid reported to for 1099 purposes. *Example: If you are an individual completing this question, please input your Social Security Number unless you are a sole proprietor. An individual provider can bill under his/her individual provider number even if they are working in a group setting. If you are applying as an individual and do not own a FEIN, but you want your monies reported to the FEIN of the entity, you must complete a Map-347 (Statement of Authorization of Payment) so your individual number can be linked to the group KY Medicaid provider number.*
- 18 Please indicate the address where you want your Medicaid 1099 mailed.
- 19 Enter telephone number and extension of where you want your Medicaid 1099 mailed.
- 20 Enter the contact name for the Medicaid 1099.
- 21 Please attach a listing of all professionals currently employed in your group. Include provider name, begin date (if known), and the individual's Medicaid provider number.
- 22 Please attach a copy of your W-9 form if you are a sole owner of a FEIN and want your monies reported to that FEIN. Please attach a copy of your Social Security Card or signed notarized statement if you are not a sole owner of a FEIN.

Section C: Tax Structure

Field #	Description
---------	-------------

- | | |
|---|---|
| 1 | Check block, which pertains to applicant's tax structure. |
|---|---|

Revised 01/09

- If "B" is marked, please complete number 2 with name, address, city, state, zip code, and telephone number.
- If "C" is marked, please complete number 3 with name, address, city, state, zip code and FEIN/SSN.
- If "E" is marked, please attach a list of Officer and Board Members.
- If "F" is marked, please attach list of Board Members.
- If "G" is marked, please attach list of Board Members.
- If "H" is marked, please attach list of Limited Liability members.

Page 10 (Signature Page)

Provider Signature: Individual provider must sign original signature in blue ink. (Copied or stamped signatures are not accepted.)

Name: Printed name of provider

Title: Title of person signing. EXAMPLE: doctor, physician assistant, etc...

Date: Enter the date the agreement was signed

Witnessed By: Enter original blue ink signature of witness (Copied or stamped signatures are not accepted.)

Health Care Partnership Signature:

To be completed by Managed Care representative only

Regional Transportation Broker Signature:

This field is to be completed by the transportation broker. All taxi providers, non-ambulatory specialty carriers, and bus-co-ops must have this field completed. If field is incomplete the application will be rejected for participation with the Kentucky Medicaid program.

Department for Medicaid Services:

To be completed by Department for Medicaid Services representative

For Kentucky Medicaid Use Only

ATN# _____

ATN# _____

ATN# _____

Identifier: _____

Provider Type: _____

Reviewer's Initials: _____

- 1 -

SECTION B: DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

ITEMS 1-15 BELOW ARE REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.104 AND KRS CHAPTER 205, AS AMENDED). YOU WILL RECEIVE THIS SECTION ANNUALLY TO UPDATE AND RETURN TO DMS.

Note: See page 6 for definitions according to 42 CFR 455.101 and 455.104 and KRS Chapter 205, as amended, of underlined terms in Section B.

1. List all current Kentucky Medicaid provider numbers: N/A

2. If there has been a change in ownership, change of tax ID number (FEIN), or change in Kentucky Provider Number for a previously enrolled Kentucky Medicaid provider, please state previous provider number(s) and their effective date(s):

N/A Previous Medicaid Prov. # Mo. Day Yr. to Mo. Day Yr.

 Previous Medicaid Prov. # Mo. Day Yr. to Mo. Day Yr.

3. If you completed #2, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. Attach extra page if necessary.

N/A

4. If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. Date: Change: N/A

5. If you anticipate filing for bankruptcy within the year, state anticipated date of filing. N/A

6. If this facility is a subsidiary of a parent corporation, state corporate FEIN #: N/A

Name:

Box or Address:

City:

State: Zip:

7. List name, date of birth, SSN#/FEIN#, and address of each person or organization that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. If owned by a corporation, please list names and social security numbers of Officers and Board Members of that corporation. (Attach extra page if necessary.) If you are applying as an individual, please list your information. (N/A not acceptable.)

☐ Check here if no one has 5% or more direct or indirect ownership, and skip to item #8.

NAME (a): Jane Doe

DOB: 1-1-1975

Box or Address: 123 Dny St.

SSN: 123-45-6789

City: Frankfort

-and/or-

FEIN:

State: K Zip: 40601

NAME (b): _____ DOB: _____
Box or Address: _____ SSN: _____
-and/or- _____
City: _____ FEIN: _____
State: [] [] Zip: _____ - _____

8. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. Attach extra page if necessary.

NAME (a): N/A _____ SSN: _____
Box or Address: _____ -and/or- _____
City: _____ FEIN: _____
State: [] [] Zip: _____ - _____

NAME (b): _____ SSN: _____
Box or Address: _____ -and/or- _____
City: _____ FEIN: _____
State: [] [] Zip: _____ - _____

9. If any individuals listed in item #8 (above) are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.)

Name: <u>N/A</u> _____	Name: _____
Relationship: _____	Relationship: _____
SSN: _____	SSN: _____
-and/or- _____	-and/or- _____
FEIN: _____	FEIN: _____

10. If this facility employs a management company, please provide following information:

Name: N/A _____
Box or Address: _____
City: _____
State: [] [] Zip: _____ - _____

11. List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities.

NAME (a): N/A _____ Provider #: _____
Box or Address: _____
City: _____
State: [] [] Zip: _____ - _____

Example Example Example Example Example Example Example

NAME (b): _____ Provider #: _____

Box or Address: _____

City: _____

State: [] [] Zip: _____ - _____

12. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of \$25,000 or 5% of your total operating expense. (Attach extra page if necessary.)

NAME (a): N/A _____

Box or Address: _____

City: _____

State: [] [] Zip: _____ - _____

NAME (b): _____

Box or Address: _____

City: _____

State: [] [] Zip: _____ - _____

13. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477.

NAME (a): N/A _____

Credential (M.D., etc.): _____

Box or Address: _____

DOB: _____

City: _____

SSN: _____

State: [] [] Zip: _____ - _____

NAME (b): _____

Credential (M.D., etc.): _____

Box or Address: _____

DOB: _____

City: _____

SSN: _____

State: [] [] Zip: _____ - _____

Example Example Example Example Example Example Example

14. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state, since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), please indicate below. (Attach extra page if necessary.)

NAME (a)/Provider Number(s)

NAME (b)/Provider Numbers(s)

N/A

15. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), please indicate below. (Attach extra page if necessary.)

NAME (a)/Provider Number(s)

NAME (b)/Provider Number(s)

N/A

16. For any previously enrolled Medicaid provider, please list any change in:

Administrator: N/A

Director of Nursing (DON):

Medical Director:

17. DMS will report all monies paid to you to the IRS. Please indicate which number you use for tax reporting:

(If you are enrolling as an individual and do not own a FEIN, please complete SSN field only.)

Report DMS payments to my FEIN: [] [] [] [] [] [] [] [] [] []

Report DMS payments to my SSN: [1] [2] [3] [4] [5] [6] [7] [8] [9]

18. Where do you want your Medicaid 1099 (annual earnings form) mailed?

Name: Jane Doe

Box or Address: 123 Main St.

City: Frankfort

State: [K] [Y] Zip: 40601

19. (502) 123-8900
Telephone # Ext.

20. Contact Person (First and Last Name) Jane Doe

21. If you are a Kentucky Medicaid Group (more than one professional of the same provider type) please attach a listing of all professionals currently employed in your group. Include the provider name, begin date with the group and the individuals Kentucky Medicaid provider number.

22. Please attach a copy of your W-9 form if you are a sole owner of a FEIN and want your monies reported to your FEIN. Please attach a copy of your Social Security Card or notarized statement signed by you attesting to your SSN if you are not a sole owner of a FEIN.

MAP-811 Individual Rev 01/09 Fill out all Applicable Sections. Write Not Applicable (N/A) for questions that do not apply.
Applications will be rejected for any questions left blank. Please print or type.

455.104 Definitions:

1. Indirect Ownership Interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
2. Other Disclosing Entity Means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
 - (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
 - (b) Any Medicare intermediary or carrier; and
 - (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishings of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.
3. Person with an Ownership or Control Interest means a person or corporation that:
 - (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
 - (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
 - (c) Has a combination of direct or indirect ownership interests equal to 5 percent or more in a disclosing entity;
 - (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
 - (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
 - (f) Is a partner in a disclosing entity that is organized as a partnership
4. Subcontractor means:
 - (a) An individual, agency, organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
 - (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

SECTION C: TAX STRUCTURE

1. Provider Tax Structure of Applicant: Please check only one (1).

- ☒ (A) Individual
☐ (B) Sole Proprietor
☐ (C) Partnership
☐ (D) Estate/Trust
☐ (E) Corporation (please attach a list of Officers' and Board Members' names or list below).
☐ (F) Public Service Corporation (please attach a list of Officers' and Board Members' names or list below).
☐ (G) Government/Non-Profit (please attach a list of Officers' and Board Members' names or list below).
☐ (H) Limited Liability Company (please attach a list of Officers' and Board Members' names or list below).

2. If tax structure is (B) Sole Proprietor, give name, d.b.a. (if applicable), address, and telephone number of owner:

N/A
Name (and d.b.a. if applicable)

Address _____ City _____
[][] - ()
State (2-digit) Zip Telephone # Ext.

3. If tax structure is "C" Partnership, list name, address, and the social security numbers of partners:

Name	Address	SSN
<u>N/A</u>		

Officers' and Board Members' Names:

Example Example Example Example Example Example Example

MAP-811 Individual Rev 01/09 Fill out all Applicable Sections. Write Not Applicable (N/A) for questions that do not apply.
Applications will be rejected for any questions left blank. Please print or type.

WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. (42USC 1320A-7B, CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS IS PRINTED ON PAGE 11) FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIPATE IN OR TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104 AND KRS CHAPTER 205 AS AMENDED.

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I certify that I have read and understand the "Medicaid Rules, Regulation, Policy and 42USC 1320a-7b" (pp. 9-11) to the best of my ability. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health and Family Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program. I also understand that the KAPER-1 (Kentucky Application for Provider Evaluation and Re-evaluation) or CAQH application is considered a continuation of my contract with the KY Department for Medicaid Services. I further certify that, if I keep medical records on an electronic database, those records are confidential and patient privacy is protected (KRS 205.510).

Provider Signature:
(BLUE INK ONLY)

Jane Doe

Name (please print): Jane Doe

Title: ARNP

Date: 8-1-10

Witnessed by (Signature): Melissa Doe

Health Care Partnership Signature:
(BLUE INK ONLY)

Name (please print): _____

Title: _____

Date: _____

Regional Transportation Broker Signature:

Broker Name: _____

Broker Signature: _____

(BLUE INK ONLY)

Approval Date: _____

Department for Medicaid Services:

Name: _____

Title: _____

Date: _____

NOTE: Please ensure that no questions were left blank before submitting application.

PLEASE MAKE A COPY OF COMPLETED PAGES FOR YOUR RECORDS. YOU WILL RECEIVE A DMS-SIGNED COPY OF THIS PAGE ALONG WITH NOTIFICATION OF YOUR KENTUCKY MEDICAID PROVIDER NUMBER.

MEDICAID RULES, REGULATION, POLICY AND 42USC 1320a-7b

1. Scope of Agreement:

This provider agreement sets forth the rights, responsibilities, terms and conditions governing the provider's participation in the Kentucky Medicaid Program, KenPAC, KCHIP and/or Kentucky Health Care Partnership and supplements those terms and conditions imposed by these four (4) programs.

2. Medical Services to be Provided:

The provider agrees to provide covered services to Medicaid, KenPAC and KCHIP recipients in accordance with all applicable federal and state laws, regulations, policies and procedures relating to the provision of medical services according to Title XIX, Title VI, the approved Waivers for Kentucky and, for those providers participating in the Partnership, all applicable provisions of the pertinent contract for managed care and policies and procedures duly adopted by the governing board of the Partnership applicable to provider and recipients of Title XIX services.

3. Assurances:

The Provider:

- (1) Agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to KCHIP and Title XIX recipients for a minimum of five (5) years or as required by state and federal laws, and for such additional time as may be necessary in the event of an audit exception, quality of care issue, or other dispute and to furnish the state or federal agencies with any information requested regarding payments claimed for furnishing services.
- (2) Agrees to permit representatives of the state and federal government, and, for those providers participating in the Partnership, staff of the Kentucky Health Care Partnership to have the unrestricted right to examine, inspect, copy and audit all records pertaining to the provision of services furnished to KCHIP and Title XIX recipients. Such examinations, inspections, copying and audits may be made without prior notice to the Provider. This right shall include the ability to interview facility staff during the course of any inspection, review, investigation or audit.
- (3) Agrees to comply with the Civil Rights requirements set forth in 45 CFR Parts 80, 84, and 90 and the Americans with Disabilities Act (ADA), 42 USC 12101. Payments shall not be made to providers who discriminate on the basis of race, color, national origin, sex, disability, religion, age or marital status in the provision of services.
- (4) Agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for KCHIP and Title XIX recipients in order to ensure quality of care and avoid the provision of duplicate or unnecessary medical services.
- (5) Assures awareness of the provisions of 42 USC 1320a-7b reproduced on page 11 of this agreement and of the provisions of KRS 205.8451 to KRS 205.8483 relating to Medicaid Program Fraud and Abuse, and applicable Kentucky Administrative Regulations as specified in Title 907 relating to the Kentucky Health Care Partnerships and Provider Agreements.
- (6) Agrees to inform the Cabinet for Health Services, Department for Medicaid Services or the appropriate Partnership.
 - A. within thirty-five (35) days of any change in the following:
 1. name;
 2. ownership;
 3. address; and,
 - B. within five (5) days of information concerning the following:
 1. change in licensure/certification;
 2. regulation status;
 3. disciplinary action by the appropriate professional association; and,
 4. criminal charges
- (7) Agrees to the following:
 - A. To assume responsibility for appropriate, accurate, and timely submission of claims and encounter data whether submitted directly by the provider or by an agent;
 - B. To use EMC submittal procedures and record layouts as defined by the Cabinet if submitting electronic claims.
 - C. That the provider's signature on this agreement constitutes compliance with the following: the transmitted information is true, accurate and complete and any subsequent correction which alters the information contained therein will be transmitted promptly;
 - D. Payment and satisfaction of claims will be from federal and state funds and that any false claims, statements, or documents or concealment of falsification of a material fact, may be prosecuted under applicable federal and state law.
- (8) Agrees to participate in the quality assurance programs of the partnership and the Department for Medicaid Services and understands that the data will be used for analysis of medical services provided to assure quality of care according to professional standards.
- (9) A contract for the sale or change of ownership participating in the Medicaid Program shall specify whether the buyer or seller is responsible for the amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of sale. In the absence of such specification in the contract for the sale or change of ownership, the owners or the partners at the time the department paid the erroneous payments have the responsibility for liabilities arising from those payments, regardless of when identified.
- (10) Agrees to notify the Department for Medicaid Services and/or the Partnership in writing of having filed for protection from creditors under the Bankruptcy code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court, and the identity of the court in which the petition was filed.
- (11) Agrees to return any overpayment made by the Department for Medicaid Services and/or Partnership resulting from agency error in calculation of amount or review of submitted claims.
- (12) Agrees to comply with employee education for false claims recovery deficit reduction act (DRA) of 2005, Section 6032. More information can be found at <http://chfs.ky.gov/dms/provider.htm>.

MAP-811 Individual Rev 01/09 Fill out all Applicable Sections. Write Not Applicable (N/A) for questions that do not apply.
Applications will be rejected for any questions left blank. Please print or type.

4. ITEM # 4 APPLIES ONLY TO LONG TERM CARE FACILITIES (NF, ICF/MR or Mental Hospital), AND HOME COMMUNITY BASED Waiver SERVICES (HCB, SCL, Model Waiver II, Acquired Brain Injury, etc.)

As a result of the Medicare Catastrophic Coverage Act of 1988, each facility providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Department for Community Based Services through a contractual arrangement with the Department for Medicaid Services. This requirement is a Condition of Participation in the Kentucky Medicaid Program, in accordance with 907 KAR 1:672 and is effective with new admissions on and after September 30, 1989.

Each nursing facility agrees to comply with the preadmission screening and resident review requirement specified in Section 1919 of the Social Security Act, effective with regard to admissions and resident stays occurring on or after January 1, 1989.

5. Payment:

In consideration for the provision of approved Title XIX services rendered to Medicaid recipients and Title XXI services rendered to KCHIP recipients and subject to the availability of federal and state funds:

- (1) The Cabinet for Health Services, Department for Medicaid Services agrees to reimburse the provider according to current applicable federal and state laws, rules and regulations and policies of the Cabinet for Health Services for providers participating as direct Medicaid payment providers. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Health and Family Services, Department for Medicaid Services.
- (2) The Partnership agrees to reimburse the provider according to the provisions of the Partnership agreement with the provider. Payments shall be made only upon receipt of appropriate encounter data, claims and reports as prescribed by the Partnership governing board.
- (3) In accordance with 42 CFR 447.15, if the department makes payment for a covered service and the provider accepts this payment in accordance with the department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. A provider may not bill a Medicaid recipient for a bill that was denied due to incorrect billing. A provider may bill a Medicaid recipient under the following conditions:

- a. Service not covered by Kentucky Medicaid, and member was previously informed of the non-covered service.
- b. Provider is not enrolled in Kentucky Medicaid.

6. Provider Certification:

- (1) If the provider is required to participate or hold certification under Title XVIII of the Social Security Act to provide Title XIX services, the provider assures such participation or certification is current and active.
- (2) If the Provider is a specialty hospital providing psychiatric services to persons age twenty-one (21) and under, the Provider shall be approved by the Joint Commission on Hospitals or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that are recognized by the state. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on the Accreditation of Health Care Organizations.
- (3) Home Care Waiver Services agrees to comply with the conditions for participation established in 907 KAR 1:070. All staff shall meet all training requirements prior to providing services.
- (4) Personal Care Assistance Programs agree to comply with the conditions for participation established in 907 KAR 1:090. All staff shall meet all training requirements prior to providing services.

7. Lobbying Certification:

The provider certifies that to the best of one's knowledge and belief, that during the preceding contract period, if any, and during the term of this agreement:

- (1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influence or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL 'Disclosure Form to Report Lobbying' in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.
- (4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into, submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352 Title 31, US code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for such failure.

8. Termination

- (1) The Department for Medicaid Services and/or partnership or provider shall have the right to terminate this agreement for any reason with up to thirty (30) days written notice served upon the other party by registered mail with return receipt requested. The Partnership and/or Department for Medicaid Services may terminate this agreement immediately for cause, or in accordance with state or federal laws, upon written notice served upon the Provider by registered mail with return receipt requested.
- (2) If Medicare or Medicaid terminates the provider, the Partnership shall also terminate the provider from participation.
- (3) If there is a change of ownership of nursing facility, the Cabinet for Health and Family Services agrees to automatically assign this agreement to the new owner according to 42 CFR 442.14.
- (4) Failure of a provider to comply with the terms of this agreement may result in the initiation of the following sanctions:
 - Freezing member enrollment with the provider.
 - Withholding all or part of the provider's monthly management fee.
 - Making a referral to the Division of Fraud, Waste, & Abuse/Identification and Prevention in the Office of Inspector General for investigation of potential fraud or quality of care issues.
 - Terminating the provider from the KenPAC program.

The Department will allow the provider two weeks to cure any violation that could result in the sanctioning of the provider. If the provider does not or refuses to cure the violation, the Department will proceed with action to impose sanctions on the provider. If sanctions are applied against the provider, the action will be reported to the appropriate professional boards and/or agencies. One or more of the above sanctions may be initiated simultaneously at the discretion of the Department based on the severity of the contraction violation. The Commissioner makes the determination to initiate sanctions against a provider. The provider will be notified of the initiation of a sanction by certified mail.

42USC Section 1320a-7b. Criminal Penalties for Acts Involving Federal Health Care Programs

- (a) Making or causing to be made false statements or representations
 Whoever-
- (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section).
- (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.
- (3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.
- (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.
- (5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not a licensed physician, or
- (6) knowingly and willfully disposed of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets in the imposition of a period of ineligibility for such assistance under section 1396p of this title, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which the payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such periods (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between the individual and such other person.
- (b) Illegal remunerations
- (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind
- (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
- (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (2) whoever knowingly and willfully offers or pays any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-
- (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
- (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (3) Paragraphs (1) and (2) shall not apply to-
- (A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;
- (B) any amount paid by an employer (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;
- (C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if-
- (i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and
- (ii) in the case of an entity that is a provider of services (as defined in section 1395x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;
- (D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act (42 U.S.C.A. section 201 et seq.);
- (E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987; and
- (F) any remuneration between an organization and an entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1395mm of this title or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide.
- (c) False statements or representations with respect to condition or operation of institutions
 Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, rural primary care hospital, skilled nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter of a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (d) Illegal patient admittance and retention practices
 Whoever knowingly and willfully-
- (1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State, or
- (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)-
- (A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or
- (B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (e) Violation of assignment terms
 Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(b)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than six months, or both.
- (f) "Federal health care program" defined
 For purposes of this section, the term "Federal health care program" means-
- (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of Title 3); or
- (2) any State health care program, as defined in section 1320a-7(h) of this title.

Provider Application

CORRECT NUMBERS
AND LETTERS

A B C 1 2 3

CORRECT
MARK

X

INCORRECT
MARKS

✓

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING,
COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE
MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions
carefully prior to
submitting your
application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1

Personal Information and Professional IDs

Provider Type

037

Code list is found on page 36. Enter the
associated 3-digit code in the space
provided.*

YES X NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?
(E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE
PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames
or initials, unless they
are part of your legal
name.

DOE

LAST NAME*

SUFFIX (JR, III)

JANE

FIRST NAME*

MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?*

YES

X NO

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

SUFFIX (JR, III)

OTHER FIRST NAME

OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME

DATE STOPPED USING OTHER NAME

General Information

Only enter a Foreign
National Identification
Number if you do not
have a SSN. Do not
enter National Provider
Identification (NPI)
Number here.

Code lists are found on
pages 36-43. Enter the
associated 3-digit code
in the space provided.

GENDER*

MALE

X FEMALE

DATE OF BIRTH*

01011975

CITY OF BIRTH

STATE OF
BIRTH

COUNTRY OF
BIRTH

SSN*

123456789

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH
LANGUAGES YOU SPEAK

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

Home Address

NUMBER

STREET

APT NUMBER

CITY

STATE

ZIP CODE

TELEPHONE

NOTE: CAQH will use
this method for
application follow-up.

E-MAIL

FAX

PREFERRED METHOD OF CONTACT*

E-MAIL

FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

Non-licensed professionals should enter certification/registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

FEDERAL DEA NUMBER

DEA ISSUE DATE

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☒ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☒ YES ☐ NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ YES ☒ NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)

3077

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Example Example Example Example Example Example Example

Section 2**Education and Training****Undergraduate School(s)**

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

START DATE

END DATE (GRADUATION DATE)

DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL?

YES

NO

GRADUATE TYPE*:☒

U.S. OR CANADIAN GRADUATE

NON-U.S./CANADIAN GRADUATE

FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./CANADIAN ONLY)

NAME OF U.S./CANADIAN SCHOOL:

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

YES

NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY

COUNTRY CODE

POSTAL CODE

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

YES

NO

Example Example Example Example Example Example Example

3078

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SCHOOL CODE (E.G.,
AFFILIATED MEDICAL
SCHOOL)

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS
INSTITUTION?

YES

NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each
department
separately, if
applicable.

List
Internship/
Residency,
Fellowship
and Other
programs
separately.

INTERNSHIP/
RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/
RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/
RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3080

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Example Example Example Example Example Example Example

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE	INITIAL CERTIFICATION DATE	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	YES	NO
BOARD CERTIFIED? YES NO	RECERTIFICATION DATE (IF APPLICABLE)	PPO	YES	NO	
CERTIFYING BOARD CODE	EXPIRATION DATE (IF APPLICABLE)	POS	YES	NO	
<p>IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR <input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM. <input type="checkbox"/></p> <p>CERTIFYING BOARD CODE</p> <p>IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.</p>					

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY CODE	INITIAL CERTIFICATION DATE	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	YES	NO
BOARD CERTIFIED? YES NO	RECERTIFICATION DATE (IF APPLICABLE)	PPO	YES	NC	
CERTIFYING BOARD CODE	EXPIRATION DATE (IF APPLICABLE)	POS	YES	NC	
<p>IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR <input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM. <input type="checkbox"/></p> <p>CERTIFYING BOARD CODE</p> <p>IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.</p>					

Example Example Example Example Example Example Example

3081

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3

Professional / Medical Specialty Information (Continued)

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

	YES	NO	EXPIRATION DATE		YES	NO	EXPIRATION DATE
BASIC LIFE SUPPORT?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	01-01-2011	ADV LIFE SUPPORT IN OB?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	01-01-2011
CPR?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	01-01-2011	ADV TRAUMA LIFE SUPPORT?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	01-01-2011
ADV CARDIAC LIFE SPT?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	01-01-2011	PEDIATRIC ADVANCED LIFE SPT?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	01-01-2011
NEONATAL ADVANCED LIFE SPT?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	01-01-2011				

Practice Interests

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

Practice Interests section with grid lines for handwritten input.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION.

Primary Credentialing Contact section with handwritten information:

LAST NAME: TUCKER

FIRST NAME: LORI

NUMBER: 123 STREET: ANY ST SUITE/BUILDING: FRANKFORT

CITY: KY STATE: 40401 ZIP CODE

TELEPHONE: 502 123 8900 FAX: 502 123 8901

E-MAIL ADDRESS: LORI.TUCKER@YAHOO.COM

NOTE:

Even if you checked the boxes above, please provide the e-mail address, if available.

3082

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Example Example Example Example Example Example Example

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?*

☒ YES ☐ NO

PREVIOUS OR FUTURE START DATE?

ANY COUNTY HEALTH DEPARTMENT
PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

123
NUMBER*

ANY ST
STREET*

SUITE/BUILDING

FRANKFORT
CITY*

KY
STATE*

40601
ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?*

☒ YES ☐ NO

5021238900
TELEPHONE*

5021238901
FAX

ANYCOUNTY@YAHOO.COM
OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID

GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)*

USE INDIVIDUAL TAX ID

USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

SMITH
LAST NAME*

JANET
FIRST NAME*

M.I.

5021238900
TELEPHONE*

5021238901
FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

SMITH
LAST NAME*

JANET
FIRST NAME*

M.I.

123
NUMBER*

ANY ST
STREET*

SUITE/BUILDING

FRANKFORT
CITY*

KY
STATE*

40601
ZIP CODE*

5021238900
TELEPHONE*

5021238901
FAX

JANET.SMITH@YAHOO.COM
E-MAIL ADDRESS

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

3083

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Example Example Example Example Example Example Example

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information (Continued)	
Payment and Remittance YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9. CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION NOTE: Even if you checked the box above, please provide the E-mail Address of the Payee Contact	ELECTRONIC BILLING CAPABILITIES? YES <input checked="" type="checkbox"/> NO BILLING DEPARTMENT (IF HOSPITAL-BASED) CHECK PAYABLE TO* LAST NAME* DOE FIRST NAME* JANE M.I. NUMBER* 123 STREET* ANY ST SUITE/BUILDING CITY* FRANKFORT STATE* KY ZIP CODE* 40601 TELEPHONE* 502 123 8900 FAX 502 123 8901 E-MAIL ADDRESS JANET.SMITH@YAHOO.COM	

Office Hours NOTE: After hours back office telephone will be used only by the health plan and will not be published under any circumstances.	(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR) <table border="1"> <thead> <tr> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> </tr> </thead> <tbody> <tr> <td>MONDAY</td> <td></td> <td></td> <td></td> <td></td> <td>FRIDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TUESDAY</td> <td></td> <td></td> <td></td> <td></td> <td>SATURDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>WEDNESDAY</td> <td></td> <td></td> <td></td> <td></td> <td>SUNDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>THURSDAY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> 24/7 PHONE COVERAGE? IF YES <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS AFTER HOURS BACK OFFICE TELEPHONE									START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM	MONDAY					FRIDAY					TUESDAY					SATURDAY					WEDNESDAY					SUNDAY					THURSDAY									
	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM																																																	
MONDAY					FRIDAY																																																					
TUESDAY					SATURDAY																																																					
WEDNESDAY					SUNDAY																																																					
THURSDAY																																																										

Open Practice Status	ACCEPT NEW PATIENTS INTO THIS PRACTICE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT ALL NEW PATIENTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW MEDICARE PATIENTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW MEDICAID PATIENTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED) ARE THERE ANY PRACTICE LIMITATIONS? YES <input checked="" type="checkbox"/> NO IF YES GENDER LIMITATIONS: MALE ONLY <input type="checkbox"/> FEMALE ONLY <input type="checkbox"/> NONE AGE LIMITATIONS: MINIMUM AGE <input type="checkbox"/> MAXIMUM AGE <input type="checkbox"/> LIST OTHER LIMITATIONS			
-----------------------------	--	--	--	--

3084

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Example Example Example Example Example Example Example

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?

☒ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

DOE

PRACTITIONER LAST NAME

MARK

PRACTITIONER FIRST NAME

0001P

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

ARNP

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

Example Example Example Example Example Example Example

3085

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Languages

Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES
SPOKEN BY OFFICE PERSONNEL

INTERPRETERS AVAILABLE?*	YES	NO	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE
	<input checked="" type="checkbox"/>	<input type="checkbox"/>					

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?*

☒ YES ☐ NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*

☒ YES ☐ NO

ACCESSIBLE BY PUBLIC TRANSPORTATION?*

☒ YES ☐ NO

BUILDING?*

☒ YES ☐ NO

TEXT TELEPHONY (TTY)*

☒ YES ☐ NO

BUS*

☒ YES ☐ NO

PARKING?*

☒ YES ☐ NO

AMERICAN SIGN LANGUAGE*

☒ YES ☐ NO

SUBWAY*

YES ☒ NO

RESTROOM?*

☒ YES ☐ NO

MENTAL/PHYSICAL IMPAIRMENT SERVICES*

☒ YES ☐ NO

REGIONAL TRAIN*

YES ☒ NO

OTHER HANDICAPPED ACCESS

OTHER DISABILITY SERVICES

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES?

YES ☐ NO ☐

IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES?

YES ☐ NO ☐

IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGs?

YES ☐ NO ☐

ALLERGY INJECTIONS?

YES ☐ NO ☐

ALLERGY SKIN TESTING?

YES ☐ NO ☐

ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?

YES ☐ NO ☐

DRAWING BLOOD?

YES ☐ NO ☐

AGE APPROPRIATE IMMUNIZATIONS?

YES ☐ NO ☐

FLEXIBLE SIGMOIDOSCOPY?

YES ☐ NO ☐

TYMPANOMETRY/AUDIOMETRY SCREENING?

YES ☐ NO ☐

ASTHMA TREATMENT?

YES ☐ NO ☐

OSTEOPATHIC MANIPULATION?

YES ☐ NO ☐

IV HYDRATION/ TREATMENT?

YES ☐ NO ☐

CARDIAC STRESS TEST?

YES ☐ NO ☐

PULMONARY FUNCTION TESTING?

YES ☐ NO ☐

PHYSICAL THERAPY?

YES ☐ NO ☐

CARE OF MINOR LACERATIONS?

YES ☐ NO ☐

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?

YES ☐ NO ☐

IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

LAST NAME

FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)*

SOLO PRACTICE

SINGLE SPECIALTY GROUP

MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3086

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY CODE
FIRST NAME	M.I.
LAST NAME	SPECIALTY CODE
FIRST NAME	M.I.
LAST NAME	SPECIALTY CODE
FIRST NAME	M.I.

Section 5 Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES? YES ☒ NO ☐ IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

3087

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Example Example Example Example Example Example Example

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5

Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

M.I.

AFFILIATION START DATE

AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES?

YES

NO

ARE PRIVILEGES TEMPORARY?

YES

NO

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?

%

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OTHER HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

M.I.

AFFILIATION START DATE

AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES?

YES

NO

ARE PRIVILEGES TEMPORARY?

YES

NO

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?

%

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

PLEASE EXPLAIN

TERMINATED AFFILIATION

3088

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT
CARRY
MALPRACTICE
INSURANCE, CHECK
THIS BOX AND SKIP
THIS SECTION.

ACME INSURANCE

SELF-INSURED? YES ☒ NO

CARRIER OR SELF-INSURED NAME*

457 ANY STREET

NUMBER*

STREET*

SUITE/BUILDING

ANY CITY

CITY*

KY

STATE*

11111

ZIP CODE*

090109

ORIGINAL EFFECTIVE DATE*

090109

EFFECTIVE DATE*

090111

EXPIRATION DATE

TYPE OF COVERAGE?*

☒

INDIVIDUAL

SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*

☒ YES NO

AMOUNT OF COVERAGE PER OCCURRENCE

AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE?*

☒ YES NO

00011

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional insurance, use the Supplemental Insurance Form on page 31.

SELF-INSURED? YES NO

CARRIER OR SELF-INSURED NAME

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TYPE OF COVERAGE?*

INDIVIDUAL

SHARED

ORIGINAL EFFECTIVE DATE*

EFFECTIVE DATE*

EXPIRATION DATE

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*

YES NO

AMOUNT OF COVERAGE PER OCCURRENCE

AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE?*

YES NO

POLICY NUMBER*

Section 7

Work History and References

Military Duty

Are you currently on active military duty or military reserve?*

YES ☒ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

3089

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

3090

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Gaps in Professional / Work History

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALLED.

GAP START DATE

GAP END DATE

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

DOE

LAST NAME*

LOUISE

FIRST NAME*

789

NUMBER*

ANY STREET

STREET*

ANY CITY

CITY*

PROVIDER TYPE (CODE PG 36)

APT/SUITE/BUILDING

KY

STATE*

40000

ZIP CODE*

TELEPHONE

FAX

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 36)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 36)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

3091

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8

Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. YES ☒ NO ☐ Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
2. YES ☒ NO ☐ Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. YES ☒ NO ☐ Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. YES ☒ NO ☐ Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. YES ☒ NO ☐ Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. YES ☒ NO ☐ Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. YES ☒ NO ☐ Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. YES ☒ NO ☐ Have any of your board certifications or eligibility ever been revoked?*
9. YES ☒ NO ☐ Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. YES ☒ NO ☐ Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. YES ☒ NO ☐ Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. YES ☒ NO ☐ Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. YES ☒ NO ☐ To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. YES ☒ NO ☐ Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. YES ☒ NO ☐ Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. YES ☒ NO ☐ Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. YES ☒ NO ☐ Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. YES ☒ NO ☐ Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

3092

Section 8

Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to question #19, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. YES ☒ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. YES ☒ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*
21. YES ☒ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
22. YES ☒ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. YES ☒ NO Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)
24. YES ☒ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*
25. YES ☒ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*
26. YES ☒ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Example
Example
Example
Example
Example
Example
Example
Example

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

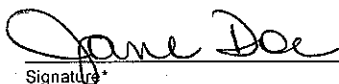
Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

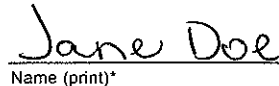
Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.


Signature*


Name (print)*

08012010
DATE SIGNED*

3094

Example
Example
Example
Example
Example
Example
Example
Example

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1	Personal Information and Professional IDs		
Professional IDs Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers. Provide all current and previous licenses/certifications. If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.	FEDERAL DEA NUMBER DEA STATE OF REGISTRATION	DEA ISSUE DATE DEA EXPIRATION DATE	
	FEDERAL DEA NUMBER DEA STATE OF REGISTRATION	DEA ISSUE DATE DEA EXPIRATION DATE	
	CDS CERTIFICATE NUMBER CDS STATE OF REGISTRATION	CDS ISSUE DATE CDS EXPIRATION DATE	
	CDS CERTIFICATE NUMBER CDS STATE OF REGISTRATION	CDS ISSUE DATE CDS EXPIRATION DATE	
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO License Status Code Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS CODE	LICENSE ISSUING STATE LICENSE ISSUE DATE LICENSE EXPIRATION DATE License Type Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided. LICENSE TYPE	
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO License Status Code Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS CODE	LICENSE ISSUING STATE LICENSE ISSUE DATE LICENSE EXPIRATION DATE License Type Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided. LICENSE TYPE	

3095

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Other Relevant Education Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2	Education and Training
Fifth Pathway Education	FIFTH PATHWAY GRADUATES ONLY <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE) </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> ADDRESS </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> CITY STATE ZIP CODE </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> TELEPHONE FAX </div> <div style="border: 1px solid black; padding: 5px;"> DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> START DATE END DATE (GRADUATION DATE) </div>
Other Relevant Education If you need to report additional Education, photocopy this page as needed and submit as instructed.	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE) </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> NUMBER STREET SUITE/BUILDING </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> CITY STATE ZIP/POSTAL CODE </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> TELEPHONE FAX </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> COUNTRY CODE START DATE END DATE (GRADUATION DATE) DEGREE AWARDED </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE) </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> NUMBER STREET SUITE/BUILDING </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> CITY STATE ZIP/POSTAL CODE </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> TELEPHONE FAX </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> COUNTRY CODE START DATE END DATE (GRADUATION DATE) DEGREE AWARDED </div> <div style="border: 1px solid black; padding: 5px;"> DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO </div>

3079

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Other Training Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Education and Training

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)		SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)	
NUMBER	STREET	SUITE/BUILDING	
CITY	STATE	ZIP/POSTAL CODE	
COUNTRY CODE	TELEPHONE	FAX	
DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION?		YES	NO
(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)			

List each department separately, if applicable.

List Internship/Residency, Fellowship and Other programs separately.

INTERNSHIP/RESIDENCY	FELLOWSHIP	OTHER	START DATE	END DATE
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)				
NAME OF DIRECTOR				
INTERNSHIP/RESIDENCY	FELLOWSHIP	OTHER	START DATE	END DATE
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)				
NAME OF DIRECTOR				
INTERNSHIP/RESIDENCY	FELLOWSHIP	OTHER	START DATE	END DATE
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)				
NAME OF DIRECTOR				

3096

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Additional Specialty Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3	Professional / Medical Specialty Information			
Additional Specialty Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.	SPECIALTY CODE	INITIAL CERTIFICATION DATE	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	
	BOARD CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE)	HMO	YES <input type="checkbox"/> NO <input type="checkbox"/>
	CERTIFYING BOARD CODE	EXPIRATION DATE (IF APPLICABLE)	PPO	YES <input type="checkbox"/> NO <input type="checkbox"/>
			POS	YES <input type="checkbox"/> NO <input type="checkbox"/>
	IF NOT BOARD CERTIFIED (SELECT ONE)	I HAVE TAKEN EXAM, RESULTS PENDING FOR	I INTEND TO SIT FOR AN EXAM ON	I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM
	CERTIFYING BOARD CODE			
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.			

Additional Specialty Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you need to report additional specialties, photocopy this page as needed and submit as instructed.	SPECIALTY CODE	INITIAL CERTIFICATION DATE	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	
	BOARD CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE)	HMO	YES <input type="checkbox"/> NO <input type="checkbox"/>
	CERTIFYING BOARD CODE	EXPIRATION DATE (IF APPLICABLE)	PPO	YES <input type="checkbox"/> NO <input type="checkbox"/>
			POS	YES <input type="checkbox"/> NO <input type="checkbox"/>
	IF NOT BOARD CERTIFIED (SELECT ONE)	I HAVE TAKEN EXAM, RESULTS PENDING FOR	I INTEND TO SIT FOR AN EXAM ON	I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.
	CERTIFYING BOARD CODE			
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.			

3097

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Partners/Associates Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information

Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # PRIMARY PRACTICE PRACTICE NAME
PRACTICE ADDRESS

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

3098

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Covering Colleagues Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.

Practice Location Information

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION #

PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

3099

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information - Page 1 of 5

Additional Practice Location

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

LOCATION*

CURRENTLY
PRACTICING AT
THIS ADDRESS?*

YES

NO

PREVIOUS
OR FUTURE
START DATE?

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

SEND GENERAL
CORRESPON-
DENCE HERE?*

YES

NO

TELEPHONE*

FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID

GROUP TAX ID

PRIMARY
TAX ID
(ONE ONLY)*

USE INDIVIDUAL
TAX ID

USE GROUP
TAX ID

LAST NAME*

FIRST NAME*

M.I.

TELEPHONE*

FAX

E-MAIL ADDRESS

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

3100

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information - Page 2 of 5

Add'l Practice Location (Cont.)

Payment and Remittance

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

LOCATION*

ELECTRONIC BILLING CAPABILITIES?*

YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?*

IF YES

AFTER HOURS BACK OFFICE TELEPHONE

YES

NO

ANSWERING SERVICE

VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE

VOICE MAIL WITH OTHER INSTRUCTIONS

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*

YES

NO

ACCEPT ALL NEW PATIENTS?*

YES

NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*

YES

NO

ACCEPT NEW MEDICARE PATIENTS?*

YES

NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*

YES

NO

ACCEPT NEW MEDICAID PATIENTS?*

YES

NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?*

IF YES

GENDER LIMITATIONS

AGE LIMITATIONS

LIST OTHER LIMITATIONS

YES

NO

MALE ONLY

NONE

MINIMUM AGE

FEMALE ONLY

MAXIMUM AGE

3101

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information - Page 3 of 5

Additional Practice Location

(Continued)

IMPORTANT

In the box provided,
indicate to which
practice location this
page belongs.

Mid-Level Practitioners

LOCATION* #

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?

YES

NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

3102

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4		Practice Location Information - Page 4 of 5									
Additional Practice Location (Continued)	→ LOCATION* #										
	LANGUAGES NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE INTERPRETERS AVAILABLE?* YES NO LANGUAGES INTERPRETED LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE										
Important In the box provided, indicate to which practice location this page belongs.	Accessibilities	DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO									
		DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING				DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO				ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO	
		BUILDING?* YES NO				TEXT TELEPHONY (TTY)* YES NO				BUS* YES NO	
		PARKING?* YES NO				AMERICAN SIGN LANGUAGE* YES NO				SUBWAY* YES NO	
		RESTROOM?* YES NO				MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO				REGIONAL TRAIN* YES NO	
OTHER HANDICAPPED ACCESS		OTHER DISABILITY SERVICES				OTHER TRANSPORTATION ACCESS					
Services	Does this location provide any of the following services?										
	LABORATORY SERVICES? YES NO		IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)								
	RADIOLOGY SERVICES? YES NO		IF YES, PROVIDE X-RAY CERTIFICATION TYPE								
	EKGs? YES NO		ALLERGY INJECTIONS? YES NO		ALLERGY SKIN TESTING? YES NO		ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO				
	DRAWING BLOOD? YES NO		AGE APPROPRIATE IMMUNIZATIONS? YES NO		FLEXIBLE SIGMOIDOSCOPY? YES NO		TYMPANOMETRY/AUDIOMETRY SCREENING? YES NO				
	ASTHMA TREATMENT? YES NO		OSTEOPATHIC MANIPULATION? YES NO		IV HYDRATION/TREATMENT? YES NO		CARDIAC STRESS TEST? YES NO				
	PULMONARY FUNCTION TESTING? YES NO		PHYSICAL THERAPY? YES NO		CARE OF MINOR LACERATIONS? YES NO						
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO		IF YES, WHAT CLASS/CATEGORY DO YOU USE?								
	IF YES, WHO ADMINISTERS IT?										
	LAST NAME		FIRST NAME								
TYPE OF PRACTICE (SELECT ONE ONLY)*		SOLO PRACTICE		SINGLE SPECIALTY GROUP				MULTI-SPECIALTY GROUP			
ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)											

3103

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information - Page 5 of 5

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* #

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME

SPECIALTY CODE

COVERING
COLLEAGUE
(Y/N)?

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

COVERING
COLLEAGUE
(Y/N)?

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

COVERING
COLLEAGUE
(Y/N)?

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

COVERING
COLLEAGUE
(Y/N)?

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

LAST NAME

SPECIALTY CODE

FIRST NAME

M.I.

PROVIDER TYPE (CODE PG 36)

3104

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Hospital Privileges (Current)

Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED), NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5

Hospital Affiliations

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

M.I.

FULL, UNRESTRICTED
PRIVILEGES?

YES

NO

ARE PRIVILEGES
TEMPORARY?

YES

NO

AFFILIATION START DATE

AFFILIATION END DATE

OF YOUR TOTAL ANNUAL
ADMISSIONS, WHAT PERCENTAGE
IS TO THIS HOSPITAL?

%

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

PLEASE EXPLAIN
TERMINATED AFFILIATION

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

3105

* REQUIRED RESPONSE (IF THIS PAGE IS USED), NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

				SELF-INSURED?	YES	NO
CARRIER OR SELF-INSURED NAME						
NUMBER*		STREET*			SUITE/BUILDING	
CITY*		STATE*			ZIP CODE*	
ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE		TYPE OF COVERAGE?*
						INDIVIDUAL SHARED
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		YES NO		AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE		
POLICY INCLUDES TAIL COVERAGE?		YES NO				
POLICY NUMBER*						

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

				SELF-INSURED?	YES	NO
CARRIER OR SELF-INSURED NAME						
NUMBER*		STREET*			SUITE/BUILDING	
CITY*		STATE*			ZIP CODE*	
ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE		TYPE OF COVERAGE?*
						INDIVIDUAL SHARED
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		YES NO		AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE		
POLICY INCLUDES TAIL COVERAGE?		YES NO				
POLICY NUMBER*						

3106

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Work History Supplemental Form

★ REQUIRED RESPONSE (IF THIS PAGE IS USED): NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History

Work History

Use this form to continue listing work history.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

3107

★ REQUIRED RESPONSE (IF THIS PAGE IS USED): NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Training / Work History Gaps Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Professional Training / Work History Gaps
Professional Training / Work History Gaps Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.	<div style="display: flex; justify-content: space-between;"> GAP START DATE GAP END DATE </div> <div style="border: 1px dotted black; height: 100px; margin-top: 5px;"></div>
	<div style="display: flex; justify-content: space-between;"> GAP START DATE GAP END DATE </div> <div style="border: 1px dotted black; height: 100px; margin-top: 5px;"></div>
	<div style="display: flex; justify-content: space-between;"> GAP START DATE GAP END DATE </div> <div style="border: 1px dotted black; height: 100px; margin-top: 5px;"></div>
	<div style="display: flex; justify-content: space-between;"> GAP START DATE GAP END DATE </div> <div style="border: 1px dotted black; height: 100px; margin-top: 5px;"></div>
	<div style="display: flex; justify-content: space-between;"> GAP START DATE GAP END DATE </div> <div style="border: 1px dotted black; height: 100px; margin-top: 5px;"></div>

3108

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Malpractice Claims Explanation Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8

Malpractice Claims Explanation

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF
OCCURRENCE*

DATE CLAIM
WAS FILED*

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)

☐ OPEN

☐ CLOSED

IF SETTLED, ENTER DATE
CLAIM WAS SETTLED

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

POLICY NUMBER

METHOD OF
RESOLUTION?*

☐ DISMISSED

☐ SETTLED

☐ MEDIATION

☐ ARBITRATION

AMOUNT OF AWARD OR SETTLEMENT*

JUDGMENT FOR
DEFENDANT(S)

JUDGMENT FOR
PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)

WERE YOU THE PRIMARY
DEFENDANT OR CO-DEFENDANT?*

☐ PRIMARY
DEFENDANT

☐ CO-DEFENDANT

NUMBER OF OTHER
CO-DEFENDANTS (IF ANY)

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)

DID THE ALLEGED INJURY
RESULT IN DEATH?

☐ YES

☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED
IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?*

☐ YES

☐ NO

3110

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Code Lists

Provider Type Codes

001	Medical Doctor (MD)	030	Licensed Practical Nurse	041	Optometrist
002	Doctor of Dental Surgery (DDS)	031	Marriage/Family Therapist	042	Pharmacist
003	Doctor of Dental Medicine (DMD)	032	Massage Therapist	043	Physical Therapist
004	Doctor of Podiatric Medicine (DPM)	033	Naturopath	044	Physician Assistant
005	Doctor of Chiropractic (DC)	034	Neuropsychologist	045	Professional Counselor
007	Osteopathic Doctor (DO)	035	Midwife	046	Registered Nurse
020	Acupuncturist	036	Nurse Midwife	047	Registered Nurse First Assistant
021	Alcohol/Drug Counselor	037	Nurse Practitioner	048	Respiratory Therapist
022	Audiologist	038	Nutritionist	049	Speech Pathologist
023	Biofeedback Technician	039	Occupational Therapist		
024	Certified Registered Nurse Anesthetist	040	Optician		
025	Christian Science Practitioner				
026	Clinical Nurse Specialist				
027	Clinical Psychologist				
028	Clinical Social Worker				
029	Dietician				

License Status Codes

001	Active	008	Pending	015	Temporary
002	Canceled	009	Probation	016	Terminated
003	Denied	010	Provisional	017	Time Limited
004	Expired	011	Restricted	018	Unrestricted
005	Inactive	012	Revoked	019	Other
006	Lapsed	013	Suspended		
007	Limited	014	Surrendered		

Country Codes

004	Afghanistan	174	Comoros	334	Heard Island and McDonald Islands	498	Moldova
008	Albania	178	Congo	340	Honduras	492	Monaco
012	Algeria	180	Congo, Democratic Republic of the	344	Hong Kong	496	Mongolia
016	American Samoa	184	Cook Islands	348	Hungary	500	Montserrat
020	Andorra	188	Costa Rica	352	Iceland	504	Morocco
024	Angola	384	Cote d'Ivoire	356	India	508	Mozambique
660	Anguilla	191	Croatia	360	Indonesia	104	Myanmar
010	Antarctica	192	Cuba	364	Iran	516	Namibia
028	Antigua and Barbuda	196	Cyprus	368	Iraq	520	Nauru
032	Argentina	203	Czech Republic	372	Ireland	524	Nepal
051	Armenia	208	Denmark	376	Israel	528	Netherlands
533	Aruba	262	Djibouti	380	Italy	530	Netherlands Antilles
036	Australia	212	Dominica	388	Jamaica	540	New Caledonia
040	Austria	214	Dominican Republic	392	Japan	554	New Zealand
031	Azerbaijan	626	East Timor (provisional)	400	Jordan	558	Nicaragua
044	Bahamas	218	Ecuador	408	Kazakhstan	562	Niger
048	Bahrain	818	Egypt	414	Kenya	566	Nigeria
050	Bangladesh	222	El Salvador	296	Kiribati	570	Niue
052	Barbados	226	Equatorial Guinea	408	Korea, North	574	Norfolk Island
112	Belarus	232	Eritrea	410	Korea, South	580	Northern Mariana Islands
056	Belgium	233	Estonia	414	Kuwait	578	Norway
084	Belize	231	Ethiopia	417	Kyrgyzstan	512	Oman
204	Benin	238	Falkland Islands (Malvinas)	418	Laos	586	Pakistan
060	Bermuda	234	Faroe Islands	428	Latvia	585	Palau
064	Bhutan	242	Fiji	422	Lebanon	591	Panama
068	Bolivia	246	Finland	426	Lesotho	598	Papua New Guinea
070	Bosnia and Herzegovina	250	France	430	Liberia	600	Paraguay
072	Botswana	249	France, Metropolitan	434	Libya	604	Peru
074	Bouvet Island	254	French Guiana	438	Liechtenstein	608	Philippines
076	Brazil	258	French Polynesia	440	Lithuania	612	Pitcairn
086	British Indian Ocean Territory	260	French Southern Territories	442	Luxembourg	616	Poland
096	Brunei Darussalam	266	Gabon	446	Macau	620	Portugal
100	Bulgaria	270	Gambia	807	Macedonia	630	Puerto Rico
854	Burkina Faso	268	Georgia	450	Madagascar	634	Qatar
108	Burundi	276	Germany	454	Malawi	638	Réunion
116	Cambodia	288	Ghana	458	Malaysia	642	Romania
120	Cameroon	292	Gibraltar	462	Maldives	643	Russian Federation
124	Canada	300	Greece	466	Mali	646	Rwanda
132	Cape Verde	304	Greenland	470	Malta	654	Saint Helena
136	Cayman Islands	308	Grenada	584	Marshall Islands	659	Saint Kitts and Nevis
140	Central African Republic	312	Guadeloupe	474	Martinique	662	Saint Lucia
148	Chad	316	Guam	478	Mauritania	666	Saint Pierre and Miquelon
152	Chile	320	Guatemala	480	Mauritius	670	Saint Vincent and the Grenadines
156	China	324	Guinea	175	Mayotte		
162	Christmas Island	624	Guinea-Bissau	484	Mexico		
166	Cocos (Keeling) Islands	328	Guyana	583	Micronesia		
170	Colombia	332	Haiti				

Code Lists

Country Codes (continued)

882 Samoa	Sandwich Islands	772 Tokelau	548 Vanuatu
674 San Marino	724 Spain	776 Tonga	336 Vatican City State (Holy See)
678 São Tomé and Príncipe	144 Sri Lanka	780 Trinidad and Tobago	862 Venezuela
682 Saudi Arabia	736 Sudan	788 Tunisia	704 Viet Nam
683 Scotland	740 Suriname	792 Turkey795 Turkmenistan	092 Virgin Islands, British
686 Senegal	744 Svalbard and Jan Mayen	796 Turks and Caicos Islands	850 Virgin Islands, U.S.
690 Seychelles	748 Swaziland	798 Tuvalu	876 Wallis and Fortuna Islands
694 Sierra Leone	752 Sweden	800 Uganda	732 Western Sahara (provisional)
702 Singapore	756 Switzerland	804 Ukraine	887 Yemen
703 Slovakia	760 Syria	784 United Arab Emirates	891 Yugoslavia
705 Slovenia	158 Taiwan	826 United Kingdom	894 Zambia
090 Solomon Islands	762 Tajikistan	840 United States	716 Zimbabwe
706 Somalia	834 Tanzania	581 U.S. Minor Outlying Islands	
710 South Africa	764 Thailand	858 Uruguay	
239 South Georgia and the South	768 Togo	860 Uzbekistan	

Language Codes

001 Abkhazian	061 Kinyarwanda	121 Tonga
002 Afan (Oromo)	062 Kirghiz	122 Tsonga
003 Afar	063 Kurundi	123 Turkish
004 Afrikaans	064 Korean	124 Turkmen
005 Albanian	065 Kurdish	125 Twi
006 Amharic	066 Laothian	126 Uigur
007 Arabic	067 Latin	127 Ukrainian
008 Armenian	068 Latvian;Lettish	128 Urdu
009 Assamese	069 Lingala	129 Uzbek
010 Zerbajjani	070 Lithuanian	130 Vietnamese
011 Bashkir	071 Macedonian	131 Volapuk
012 Basque	072 Malagasy	132 Welsh
013 Bengali;Bangla	073 Malay	133 Wolof
014 Bhutani	074 Malayalam	134 Xhosa
015 Bihari	075 Maltese	135 Yiddish
016 Bislama	076 Maori	136 Yoruba
017 Breton	077 Marathi	10 Zerbajjani
018 Bulgarian	078 Moldavian	137 Zhuang
019 Burmese	079 Mongolian	138 Zulu
020 Byelorussian	080 Nauru	
021 Cambodian	081 Nepali	
022 Catalan	082 Norwegian	
023 Chinese	083 Occitan	
024 Corsican	084 Oriya	
025 Croatian	085 Pashto;Pushto	
026 Czech	086 Persian (Farsi)	
027 Danish	087 Polish	
028 Dutch	088 Portuguese	
140 English	089 Punjabi	
030 Esperanto	090 Quechua	
031 Estonian	091 Rhaeto-Romance	
032 Faroese	092 Romanian	
033 Fiji	093 Russian	
034 Finnish	094 Samoan	
035 French	095 Sangho	
036 Frisian	096 Sanskrit	
037 Galican	097 Scot Gaelic	
038 Georgian	098 Serbian	
039 German	099 Serbo-Croatian	
040 Greek	100 Sesotho	
041 Greenlandic	101 Setswana	
042 Guarani	102 Shona	
043 Gujarati	103 Sindhi	
044 Hausa	104 Singhalese	
045 Hebrew	105 Siswati	
046 Hindi	106 Slovak	
047 Hungarian	107 Slovenian	
048 Icelandic	108 Somali	
049 Indonesian	109 Spanish	
050 Interlingua	110 Sundanese	
051 Interlingue	111 Swahili	
052 Inuktitut	112 Swedish	
053 Inupiak	113 Tagalog	
054 Irish	114 Tajik	
055 Italian	115 Tamil	
056 Japanese	116 Tatar	
057 Javanese	117 Telugu	
058 Kannada	118 Thai	
059 Kashmiri	119 Tibetan	
060 Kazakh	120 Tigrinya	

Code Lists

U.S. / Canadian Professional School Codes

Alabama

300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas

003 University of Arkansas College of Medicine

Arizona

500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California

801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angeles
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado

306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut

405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia

016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida

800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia

022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii

026 John A. Burns School of Medicine

Iowa

802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois

028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana

316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas

036 University of Kansas School of Medicine

Kentucky

506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana

319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts

042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland

046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine

507 University of New England, College of Osteopathic Medicine

Michigan

049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota

052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri

410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine
056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi

- 328 University of Mississippi School of Dentistry
- 059 University of Mississippi School of Medicine

North Carolina

- 060 Duke University School of Medicine
- 061 The Brody School of Medicine at East Carolina University
- 329 University of North Carolina at Chapel Hill School of Dentistry
- 062 University of North Carolina at Chapel Hill School of Medicine
- 063 Wake Forest University School of Medicine

North Dakota

- 064 University of North Dakota School of Medicine and Health Sciences

Nebraska

- 330 Creighton University School of Dentistry
- 065 Creighton University School of Medicine
- 066 University of Nebraska College of Medicine
- 331 University of Nebraska Medical Center, College of Dentistry

New Hampshire

- 067 Dartmouth Medical School

New Jersey

- 068 Robert Wood Johnson Medical School
- 069 University of Medicine and Dentistry of New Jersey (UMDNJ)
- 332 UMDNJ, New Jersey Dental School
- 511 UMDNJ, School of Osteopathic Medicine

New Mexico

- 070 University of New Mexico School of Medicine

Nevada

- 071 University of Nevada School of Medicine

New York

- 072 Albany Medical College
- 073 Albert Einstein College of Medicine
- 074 Columbia University College of Physicians and Surgeons
- 333 Columbia University School of Dental and Oral Surgery
- 075 Joan & Sanford I. Weill Medical College of Cornell University
- 076 Mount Sinai School of Medicine of New York University
- 412 New York Chiropractic College
- 512 NY College of Osteopathic Medicine of the NY Institute of Technology
- 077 New York Medical College
- 334 New York University Krisker Dental Center
- 078 New York University School of Medicine
- 335 State University of New York at Buffalo School of Dental Medicine
- 082 State University of New York at Buffalo School of Medicine
- 336 State University of New York at Stony Brook School of Dental Medicine
- 081 State University of New York at Stony Brook School of Medicine
- 079 State University of New York College of Medicine
- 080 State University of New York Upstate Medical University
- 083 University of Rochester School of Medicine and Dentistry

Ohio

- 337 Case Western Reserve University School of Dentistry
- 084 Case Western Reserve University School of Medicine
- 085 Medical College of Ohio
- 086 Northeastern Ohio Universities College of Medicine
- 803 Ohio College of Podiatric Medicine
- 338 Ohio State University College of Dentistry
- 087 Ohio State University College of Medicine and Public Health
- 513 Ohio University College of Osteopathic Medicine
- 088 University of Cincinnati College of Medicine
- 089 Wright State University School of Medicine

Oklahoma

- 514 Oklahoma State University, College of Osteopathic Medicine
- 339 University of Oklahoma College of Dentistry
- 090 University of Oklahoma College of Medicine

Oregon

- 091 Oregon Health & Science University School of Medicine
- 340 Oregon Health Sciences University School of Dentistry
- 413 Western States Chiropractic College

Pennsylvania

- 092 Jefferson Medical College of Thomas Jefferson University

- 515 Lake Erie College of Osteopathic Medicine

- 093 MCP Hahnemann University School of Medicine
- 094 Pennsylvania State University College of Medicine
- 516 Philadelphia College of Osteopathic Medicine
- 341 Temple University School of Dentistry
- 095 Temple University School of Medicine
- 805, Temple University School of Podiatric Medicine
- 342 University of Pennsylvania School of Dental Medicine
- 096 University of Pennsylvania School of Medicine
- 343 University of Pittsburgh School of Dental Medicine
- 097 University of Pittsburgh School of Medicine

Puerto Rico

- 098 Ponce School of Medicine
- 099 Universidad Central del Caribe School of Medicine
- 100 University of Puerto Rico School of Medicine
- 344 University of Puerto Rico School of Dentistry

Rhode Island

- 101 Brown Medical School

South Carolina

- 345 Medical University of South Carolina College of Dental Medicine
- 102 Medical University of South Carolina College of Medicine
- 414 Sherman College of Chiropractic
- 103 University of South Carolina School of Medicine

South Dakota

- 104 University of South Dakota School of Medicine

Tennessee

- 105 East Tennessee State University
- 346 Meharry Medical College School of Dentistry
- 106 Meharry Medical College School of Medicine
- 347 University of Tennessee College of Dentistry
- 107 University of Tennessee College of Medicine
- 108 Vanderbilt University School of Medicine

Texas

- 348 Baylor College of Dentistry
- 109 Baylor College of Medicine
- 415 Parker College of Chiropractic
- 416 Texas Chiropractic College
- 110 Texas Tech University Health Sciences Center School of Medicine
- 111 The Texas A & M University System College of Medicine
- 517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
- 349 University of Texas Health Science Center at Houston Dental School
- 350 University of Texas Health Science Center at San Antonio Dental School
- 112 University of Texas Medical Branch at Galveston
- 113 University of Texas Medical School at Houston
- 114 University of Texas Medical School at San Antonio
- 115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah

- 116 University of Utah School of Medicine

Virginia

- 117 Eastern VA Medical School of the Medical College of Hampton Roads
- 118 University of Virginia School of Medicine Health System
- 351 Virginia Commonwealth University School of Dentistry
- 119 Virginia Commonwealth University School of Medicine

Vermont

- 120 University of Vermont College of Medicine

Washington

- 352 University of Washington School of Dentistry
- 121 University of Washington School of Medicine

Wisconsin

- 353 Marquette University School of Dentistry
- 122 Medical College of Wisconsin
- 123 University of Wisconsin Medical School

West Virginia

- 124 Joan C. Edwards School of Medicine at Marshall University
- 518 West Virginia School of Osteopathic Medicine
- 354 West Virginia University School of Dentistry
- 125 West Virginia University School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Canada

355	Dalhousie University Faculty of Dentistry
126	Dalhousie University Faculty of Medicine
357	Laval University Faculty of Dentistry
127	Laval University Faculty of Medicine
356	McGill University Faculty of Dentistry
128	McGill University Faculty of Medicine
129	McMaster University School of Medicine
130	Memorial University of Newfoundland Faculty of Medicine
131	Queen's University Faculty of Health Sciences
132	The University of Western Ontario Faculty of Medicine & Dentistry
133	Universite de Montreal Faculty of Medicine
134	Universite de Sherbrooke Faculty of Medicine
358	University of Alberta Faculty of Dentistry
135	University of Alberta Faculty of Medicine
359	University of British Columbia Faculty of Dentistry
136	University of British Columbia Faculty of Medicine
137	University of Calgary Faculty of Medicine
360	University of Manitoba Faculty of Dentistry
138	University of Manitoba Faculty of Medicine
361	University of Montreal Faculty of Dentistry
139	University of Ottawa Faculty of Medicine
362	University of Saskatchewan College of Dentistry
140	University of Saskatchewan College of Medicine
363	University of Toronto Faculty of Dentistry
141	University of Toronto Faculty of Medicine
364	University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247	Allergy & Immunology	287	Internal Medicine, Hematology	Spine	
246	Allergy & Immunology, Allergy	288	Internal Medicine, Hematology & Oncology	416	Orthopaedic Surgery, Orthopaedic Trauma
291	Allergy & Immunology, Clinical & Laboratory Immunology	450	Internal Medicine, Hepatology	803	Orthopaedic Surgery, Pediatric Orthopaedic Surgery
249	Anesthesiology	299	Internal Medicine, Infectious Disease	457	Orthopaedic Surgery, Sports Medicine
235	Anesthesiology, Addiction Medicine	451	Internal Medicine, Interventional Cardiology	119	Orthopedic
258	Anesthesiology, Critical Care Medicine	453	Internal Medicine, Magnetic Resonance Imaging (MRI)	331	Otolaryngology
126	Anesthesiology, Pain Medicine	325	Internal Medicine, Medical Oncology	458	Otolaryngology, Otolaryngic Allergy
363	Clinical Pharmacology	309	Internal Medicine, Nephrology	459	Otolaryngology, Otolaryngology/ Facial Plastic Surgery
367	Colon & Rectal Surgery	378	Internal Medicine, Pulmonary Disease	332	Otolaryngology, Otolaryngology & Neurotology
263	Dermatology	390	Internal Medicine, Rheumatology	357	Otolaryngology, Pediatric Otolaryngology
292	Dermatology, Clinical & Laboratory Dermatological Immunology	802	Internal Medicine, Sleep Medicine	417	Otolaryngology, Plastic Surgery within the Head & Neck
444	Dermatology, Dermatological Surgery	397	Internal Medicine, Sports Medicine	804	Otolaryngology, Sleep Medicine
266	Dermatology, Dermatopathology	433	Laboratories, Clinical Medical Laboratory	480	Pain Medicine, Interventional Pain Medicine
264	Dermatology, MOHS-Micrographic Surgery	481	Legal Medicine	337	Pain Medicine
443	Dermatology, Pediatric Dermatology	278	Medical Genetics, Clinical Biochemical Genetics	338	Pathology, Anatomic Pathology
268	Emergency Medicine	261	Medical Genetics, Clinical Cytogenetic	340	Pathology, Anatomic Pathology & Clinical Pathology
445	Emergency Medicine, Emergency Medical Services	277	Medical Genetics, Clinical Genetics (M.D.)	250	Pathology, Blood Banking & Transfusion Medicine
427	Emergency Medicine, Medical Toxicology	280	Medical Genetics, Clinical Molecular Genetics	344	Pathology, Chemical Pathology
348	Emergency Medicine, Pediatric Emergency Medicine	455	Medical Genetics, Molecular Genetic Pathology	302	Pathology, Clinical Pathology/Laboratory Medicine
395	Emergency Medicine, Sports Medicine	454	Medical Genetics, Ph.D. Medical Genetics	262	Pathology, Cytopathology
446	Emergency Medicine, Undersea and Hyperbaric Medicine	306	Neonatal-Perinatal Medicine	265	Pathology, Dermatopathology
391	Facial Plastic Surgery	308	Neopathology	273	Pathology, Forensic Pathology
272	Family Practice	409	Neurological Surgery	290	Pathology, Hematology
447	Family Practice, Addiction Medicine	330	Neuromusculoskeletal Medicine & OMM	298	Pathology, Immunopathology
237	Family Practice, Adolescent Medicine	440	Neuromusculoskeletal Medicine, Sports Medicine	305	Pathology, Medical Microbiology
448	Family Practice, Adult Medicine	317	Nuclear Medicine	461	Pathology, Molecular Genetic Pathology
282	Family Practice, Geriatric Medicine	318	Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine	312	Pathology, Neuropathology
396	Family Practice, Sports Medicine	315	Nuclear Medicine, Nuclear Cardiology	358	Pathology, Pediatric Pathology
225	General Practice	316	Nuclear Medicine, Nuclear Imaging & Therapy	244	Pediatrics
479	Hospitalist	321	Obstetrics & Gynecology	805	Pediatric Anesthesiology
301	Internal Medicine	260	Obstetrics & Gynecology, Critical Care Medicine	239	Pediatrics, Adolescent Medicine
449	Internal Medicine, Addiction Medicine	326	Obstetrics & Gynecology, Gynecologic Oncology	295	Pediatrics, Clinical & Laboratory Immunology
236	Internal Medicine, Adolescent Medicine	286	Obstetrics & Gynecology, Gynecology	462	Pediatrics, Developmental - Behavioral Pediatrics
248	Internal Medicine, Allergy & Immunology	303	Obstetrics & Gynecology, Maternal & Fetal Medicine	354	Pediatrics, Medical Toxicology
255	Internal Medicine, Cardiovascular Disease	320	Obstetrics & Gynecology, Obstetrics	356	Pediatrics, Neurodevelopmental Disabilities
294	Internal Medicine, Clinical & Laboratory Immunology	271	Obstetrics & Gynecology, Reproductive Endocrinology	345	Pediatrics, Pediatric Allergy & Immunology
253	Internal Medicine, Clinical Cardiac Electrophysiology	328	Ophthalmology		
257	Internal Medicine, Critical Care Medicine	441	Oral & Maxillofacial Surgery		
267	Internal Medicine, Endocrinology, Diabetes & Metabolism	411	Orthopaedic Surgery		
275	Internal Medicine, Gastroenterology	412	Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery		
285	Internal Medicine, Geriatric Medicine	456	Orthopaedic Surgery, Foot and Ankle Orthopaedics		
		406	Orthopaedic Surgery, Hand Surgery		
		415	Orthopaedic Surgery, Orthopaedic Surgery of the		

Code Lists

Specialty Codes - MD/DO Only

346	Pediatrics, Pediatric Cardiology	Hand	Neurology	413	Surgery, Surgical Oncology
347	Pediatrics, Pediatric Critical Care Medicine	242 Preventive Medicine, Aerospace Medicine	474 Psychiatry & Neurology, Pain Medicine	423	Surgery, Trauma Surgery
463	Pediatrics, Pediatric Emergency Medicine	429 Preventive Medicine, Medical Toxicology	368 Psychiatry & Neurology, Psychiatry	400	Surgery, Vascular Surgery
349	Pediatrics, Pediatric Endocrinology	112 Preventive Medicine, Occupational Medicine	809 Psychiatry & Neurology, Sleep Medicine	421	Thoracic Surgery (Cardiothoracic Vascular Surgery)
350	Pediatrics, Pediatric Gastroenterology	471 Preventive Medicine, Sports Medicine	475 Psychiatry & Neurology, Sports Medicine	442	Transplant Surgery
351	Pediatrics, Pediatric Hematology-Oncology	431 Preventive Medicine, Undersea and Hyperbaric Medicine	476 Psychiatry & Neurology, Vascular Neurology	424	Urology
352	Pediatrics, Pediatric Infectious Diseases	114 Preventive Medicine/Occupational Environmental Medicine	366 Public Health & General Preventive Medicine	811	Urology, Pediatric Urology
355	Pediatrics, Pediatric Nephrology	370 Psychiatry & Neurology, Addiction Medicine	252 Radiology, Body Imaging		
359	Pediatrics, Pediatric Pulmonology	473 Psychiatry & Neurology, Addiction Psychiatry	173 Radiology, Diagnostic Radiology		
361	Pediatrics, Pediatric Rheumatology	371 Psychiatry & Neurology, Child & Adolescent Psychiatry	430 Radiology, Diagnostic Ultrasound		
806	Pediatrics, Sleep Medicine	313 Psychiatry & Neurology, Clinical Neurophysiology	314 Radiology, Neuroradiology		
398	Pediatrics, Sports Medicine	274 Psychiatry & Neurology, Forensic Psychiatry	319 Radiology, Nuclear Radiology		
365	Physical Medicine & Rehabilitation	373 Psychiatry & Neurology, Geriatric Psychiatry	360 Radiology, Pediatric Radiology		
468	Physical Medicine & Rehabilitation, Pain Medicine	472 Psychiatry & Neurology, Neurodevelopmental Disabilities	380 Radiology, Radiation Oncology		
389	Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	311 Psychiatry & Neurology, Neurology with Special Qualifications in Child	477 Radiology, Radiological Physics		
466	Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine		381 Radiology, Therapeutic Radiology		
469	Physical Medicine & Rehabilitation, Sports Medicine		384 Radiology, Vascular & Interventional Radiology		
419	Plastic Surgery		434 Supplier		
470	Plastic Surgery, Plastic Surgery Within the Head and Neck		399 Surgery		
407	Plastic Surgery, Surgery of the		418 Surgery, Pediatric Surgery		
			420 Surgery, Plastic and Reconstructive Surgery		
			405 Surgery, Surgery of the Hand		
			425 Surgery, Surgical Critical Care		

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD	DPM	DC
2 Dentist	3 Podiatrist	1 Chiropractor
13 Dentist, Dental Public Health	231 Podiatrist, Foot & Ankle Surgery	5 Chiropractor, Internist
14 Dentist, Endodontics	230 Podiatrist, Foot Surgery	6 Chiropractor, Neurology
438 Dentist, General Practice	227 Podiatrist, Primary Podiatric Medicine	7 Chiropractor, Nutrition
16 Dentist, Oral and Maxillofacial Pathology	226 Podiatrist, Public Medicine	8 Chiropractor, Occupational Medicine
439 Dentist, Oral and Maxillofacial Radiology	228 Podiatrist, Radiology	9 Chiropractor, Orthopedic
20 Dentist, Oral and Maxillofacial Surgery	229 Podiatrist, Sports Medicine	10 Chiropractor, Radiology
15 Dentist, Orthodontics and Dentofacial Orthopedics		801 Chiropractor, Rehabilitation Specialization
17 Dentist, Pediatric Dentistry		11 Chiropractor, Sports Physician
18 Dentist, Periodontics		12 Chiropractor, Thermography
19 Dentist, Prosthodontics		

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501 Acupuncturist	753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
503 Audiologist	754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
504 Audiologist, Assistive Technology Practitioner	755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community
505 Audiologist, Assistive Technology Supplier	756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
531 Christian Science Practitioner	757 Clinical Nurse Specialist, Rehabilitation
727 Clinical Nurse Specialist	759 Clinical Nurse Specialist, School
728 Clinical Nurse Specialist, Acute Care	758 Clinical Nurse Specialist, Transplantation
729 Clinical Nurse Specialist, Adult Health	760 Clinical Nurse Specialist, Women's Health
730 Clinical Nurse Specialist, Chronic Care	513 Counselor
731 Clinical Nurse Specialist, Community Health/Public Health	514 Counselor, Addiction (Substance Use Disorder)
732 Clinical Nurse Specialist, Critical Care Medicine	515 Counselor, Mental Health
733 Clinical Nurse Specialist, Emergency	516 Counselor, Professional
734 Clinical Nurse Specialist, Ethics	533 Dietitian, Registered
735 Clinical Nurse Specialist, Family Health	536 Dietitian, Registered, Nutrition, Metabolic
736 Clinical Nurse Specialist, Gerontology	534 Dietitian, Registered, Nutrition, Pediatric
737 Clinical Nurse Specialist, Holistic	535 Dietitian, Registered, Nutrition, Renal
738 Clinical Nurse Specialist, Home Health	651 Licensed Practical Nurse
739 Clinical Nurse Specialist, Informatics	517 Marriage & Family Therapist
740 Clinical Nurse Specialist, Long-Term Care	547 Massage Therapist
741 Clinical Nurse Specialist, Medical-Surgical	549 Midwife, Certified
742 Clinical Nurse Specialist, Neonatal	652 Midwife, Certified Nurse
743 Clinical Nurse Specialist, Neuroscience	551 Naturopath
744 Clinical Nurse Specialist, Occupational Health	553 Neuropsychologist
745 Clinical Nurse Specialist, Oncology	653 Nurse Anesthetist, Certified Registered
746 Clinical Nurse Specialist, Oncology, Pediatrics	654 Nurse Practitioner
747 Clinical Nurse Specialist, Pediatrics	655 Nurse Practitioner, Acute Care
748 Clinical Nurse Specialist, Perinatal	656 Nurse Practitioner, Adult Health
749 Clinical Nurse Specialist, Perioperative	658 Nurse Practitioner, Community Health
750 Clinical Nurse Specialist, Psychiatric/Mental Health	657 Nurse Practitioner, Critical Care Medicine
751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult	659 Nurse Practitioner, Family
752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent	

Code Lists

Specialty Codes - Allied Providers (continued)

660	Nurse Practitioner, Gerontology	679	Registered Nurse, Continuing Education/Staff Development
661	Nurse Practitioner, Neonatal	675	Registered Nurse, Critical Care Medicine
662	Nurse Practitioner, Neonatal, Critical Care	682	Registered Nurse, Diabetes Educator
670	Nurse Practitioner, Obstetrics & Gynecology	683	Registered Nurse, Dialysis, Peritoneal
671	Nurse Practitioner, Occupational Health	684	Registered Nurse, Emergency
663	Nurse Practitioner, Pediatrics	685	Registered Nurse, Enterostomal Therapy
664	Nurse Practitioner, Pediatrics, Critical Care	686	Registered Nurse, Flight
666	Nurse Practitioner, Perinatal	688	Registered Nurse, Gastroenterology
667	Nurse Practitioner, Primary Care	687	Registered Nurse, General Practice
665	Nurse Practitioner, Psych/Mental Health	689	Registered Nurse, Gerontology
668	Nurse Practitioner, School	691	Registered Nurse, Hemodialysis
669	Nurse Practitioner, Women's Health	690	Registered Nurse, Home Health
537	Nutritionist	692	Registered Nurse, Hospice
538	Nutritionist, Nutrition, Education	694	Registered Nurse, Infection Control
555	Occupational Therapist	693	Registered Nurse, Infusion Therapy
556	Occupational Therapist, Ergonomics	695	Registered Nurse, Lactation Consultant
557	Occupational Therapist, Hand	696	Registered Nurse, Maternal Newborn
558	Occupational Therapist, Human Factors	697	Registered Nurse, Medical-Surgical
559	Occupational Therapist, Neurorehabilitation	699	Registered Nurse, Neonatal Intensive Care
560	Occupational Therapist, Pediatrics	700	Registered Nurse, Neonatal, Low-Risk
561	Occupational Therapist, Rehabilitation, Driver	701	Registered Nurse, Nephrology
563	Optician	702	Registered Nurse, Neuroscience
565	Optometrist	698	Registered Nurse, Nurse Massage Therapist (NMT)
566	Optometrist, Corneal and Contact Management	703	Registered Nurse, Nutrition Support
567	Optometrist, Low Vision Rehabilitation	719	Registered Nurse, Obstetric, High-Risk
571	Optometrist, Occupational Vision	720	Registered Nurse, Obstetric, Inpatient
568	Optometrist, Pediatrics	721	Registered Nurse, Occupational Health
569	Optometrist, Sports Vision	722	Registered Nurse, Oncology
570	Optometrist, Vision Therapy	725	Registered Nurse, Ophthalmic
573	Pharmacist	724	Registered Nurse, Orthopedic
574	Pharmacist, General Practice	726	Registered Nurse, Ostomy Care
807	Pharmacist, Geriatric	723	Registered Nurse, Otorhinolaryngology & Head-Neck
575	Pharmacist, Nuclear	704	Registered Nurse, Pain Management
576	Pharmacist, Nutrition Support	706	Registered Nurse, Pediatric Oncology
808	Pharmacist, Oncology	705	Registered Nurse, Pediatrics
577	Pharmacist, Pharmacotherapy	710	Registered Nurse, Perinatal
578	Pharmacist, Psychiatric	714	Registered Nurse, Plastic Surgery
580	Physical Therapist	708	Registered Nurse, Psych/Mental Health
581	Physical Therapist, Cardiopulmonary	709	Registered Nurse, Psych/Mental Health, Adult
583	Physical Therapist, Electrophysiology, Clinical	707	Registered Nurse, Psych/Mental Health, Child & Adolescent
582	Physical Therapist, Ergonomics	810	Registered Nurse, Registered Nurse First Assistant
584	Physical Therapist, Geriatrics	712	Registered Nurse, Rehabilitation
585	Physical Therapist, Hand	713	Registered Nurse, Reproductive Endocrinology/Infertility
586	Physical Therapist, Human Factors	715	Registered Nurse, School
587	Physical Therapist, Neurology	716	Registered Nurse, Urology
590	Physical Therapist, Orthopedic	718	Registered Nurse, Women's Health Care, Ambulatory
588	Physical Therapist, Pediatrics	717	Registered Nurse, Wound Care
589	Physical Therapist, Sports	617	Respiratory Therapist, Certified
592	Physician Assistant	618	Respiratory Therapist, Certified, Critical Care
593	Physician Assistant, Medical	620	Respiratory Therapist, Certified, Educational
594	Physician Assistant, Surgical	619	Respiratory Therapist, Certified, Emergency Care
596	Psychologist	622	Respiratory Therapist, Certified, General Care
597	Psychologist, Addiction (Substance Use Disorder)	621	Respiratory Therapist, Certified, Geriatric Care
598	Psychologist, Adult Development & Aging	623	Respiratory Therapist, Certified, Home Health
599	Psychologist, Behavioral	628	Respiratory Therapist, Certified, Neonatal/Pediatrics
602	Psychologist, Child, Youth & Family	627	Respiratory Therapist, Certified, Palliative/Hospice
600	Psychologist, Clinical	629	Respiratory Therapist, Certified, Patient Transport
601	Psychologist, Counseling	624	Respiratory Therapist, Certified, Pulmonary Diagnostics
603	Psychologist, Educational	626	Respiratory Therapist, Certified, Pulmonary Function Technologist
604	Psychologist, Exercise & Sports	625	Respiratory Therapist, Certified, Pulmonary Rehabilitation
605	Psychologist, Family	630	Respiratory Therapist, Certified, SNF/Subacute Care
606	Psychologist, Forensic	631	Respiratory Therapist, Registered
607	Psychologist, HealthService	632	Respiratory Therapist, Registered, Critical Care
608	Psychologist, Men & Masculinity	634	Respiratory Therapist, Registered, Educational
609	Psychologist, Mental Retardation & Developmental Disabilities	633	Respiratory Therapist, Registered, Emergency Care
610	Psychologist, Psychoanalysis	636	Respiratory Therapist, Registered, General Care
611	Psychologist, Psychotherapy	635	Respiratory Therapist, Registered, Geriatric Care
612	Psychologist, Psychotherapy, Group	637	Respiratory Therapist, Registered, Home Health
613	Psychologist, Rehabilitation	642	Respiratory Therapist, Registered, Neonatal/Pediatrics
614	Psychologist, School	641	Respiratory Therapist, Registered, Palliative/Hospice
615	Psychologist, Women	643	Respiratory Therapist, Registered, Patient Transport
672	Registered Nurse	638	Respiratory Therapist, Registered, Pulmonary Diagnostics
673	Registered Nurse, Addiction (Substance Use Disorder)	640	Respiratory Therapist, Registered, Pulmonary Function Technologist
674	Registered Nurse, Administrator	639	Respiratory Therapist, Registered, Pulmonary Rehabilitation
711	Registered Nurse, Ambulatory Care	644	Respiratory Therapist, Registered, SNF/Subacute Care
681	Registered Nurse, Cardiac Rehabilitation	646	Social Worker, Clinical
676	Registered Nurse, Case Management	648	Specialist/Technologist, Other, Biomedical Engineering
677	Registered Nurse, College Health	506	Speech-Language Pathologist
678	Registered Nurse, Community Health	649	Technician, Other, Biomedical Engineering
680	Registered Nurse, Continence Care	502	Other, Not Listed

Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers	350 American Nurses Credentialing Center
1150 ACNM Certification Council	740 American Psychological Association
360 American Academy of Ambulatory Care Nursing	750 American Psychological Society
1550 American Academy of Anesthesiologist Assistants	760 American Psychotherapy Association
230 American Academy of Audiology	290 American Society of Addiction Medicine
370 American Academy of Experts in Traumatic Stress	1650 American Speech-Language-Hearing Association
270 American Academy of Health Providers in the Addictive Disorders	250 Biofeedback Certification Institute of America
200 American Academy of Medical Acupuncture	1430 Board of Pharmaceutical Specialties
405 American Academy of Nurse Practitioners	1250 Commission on Dietetic Registration
380 American Academy of Nursing	960 Employee Assistance Professionals Association
1330 American Academy of Optometry	780 National Association for the Advancement of Psychoanalysis
1480 American Academy of Physician Assistants	1450 National Association of Boards of Pharmacy
1110 American Association for Marriage and Family Therapy	1600 National Association of Nurse Anesthetists
390 American Association of Critical Care Nurses	770 National Association of School Psychologists
1590 American Association of Nurse Anesthetists	980 National Association of Social Workers
330 American Association of Pastoral Counselors	1310 National Board for Certification in Occupational Therapy
1010 American Association of Sex Educators, Counselors and Therapists	1490 National Board for Certification of Orthopaedic Physician Assistants
710 American Board Medical Psychotherapists	790 National Board for Certified Clinical Hypnotherapists
280 American Board of Addiction Medicine	310 National Board for Certified Counselors
950 American Board of Examiners in Clinical Social Work	1630 National Board for Respiratory Care
720 American Board of Medical Psychotherapists & Psychodiagnosticians	300 National Board of Addiction Examiners
400 American Board of Nursing Specialties	800 National Board of Cognitive Behavioral Therapists
1240 American Board of Nutrition	1350 National Board of Examiners in Optometry
1300 American Board of Occupational Medicine	1090 National Certification Board for Therapeutic Massage and Bodywork
1360 American Board of Ophthalmology	210 National Certification Commission for Acupuncture and Oriental Medicine
1510 American Board of Physical Therapy Specialties	1440 National Institute for Standards in Pharmacist Credentialing
700 American Board of Professional Psychology	220 Other - Not Listed
1130 American Naturopath Certification Board	

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopaedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons

108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards

118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians